		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038083

Facility Name: Lexington of LaGrange

Address: 4735 Willow Springs Road (Number) LaGrange (City) 60525 (Zip Code)

County: Cook

Telephone Number: (708) 352-6900 **Fax #** (708) 482-0239

IDPA ID Number: 363835751001

Date of Initial License for Current Owners: 07/31/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,894	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,894	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,827	6,950	2,481	23,258	8
9	SNF/PED					9
10	ICF	11,750	3,138	262	15,150	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,577	10,088	2,743	38,408	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.28%

D. How many bed-hold days during this year were paid by Public Aid?
262 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 07/31/92

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x] New construction

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 15 and days of care provided 2,464

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	210,514	14,839	7,881	233,234		233,234		233,234			1
2	Food Purchase		143,490		143,490		143,490	(7,787)	135,703			2
3	Housekeeping	169,470	21,463		190,933		190,933		190,933			3
4	Laundry	43,104	15,938		59,042		59,042	(6,212)	52,830			4
5	Heat and Other Utilities			114,841	114,841		114,841	1,109	115,950			5
6	Maintenance	37,085		77,386	114,471		114,471	308	114,779			6
7	Other (specify):*											7
8	**TOTAL General Services**	460,173	195,730	200,108	856,011		856,011	(12,582)	843,429			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,503,803	109,879	8,690	1,622,372		1,622,372		1,622,372			10
10a	Therapy			144,181	144,181		144,181		144,181			10a
11	Activities	100,521	11,426	3,266	115,213		115,213	10	115,223			11
12	Social Services	48,127		2,258	50,385		50,385		50,385			12
13	Nurse Aide Training											13
14	Program Transportation			1,230	1,230		1,230		1,230			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,652,451	121,305	166,825	1,940,581		1,940,581	10	1,940,591			16
	C. General Administration											
17	Administrative	103,312		215,569	318,881		318,881	(215,569)	103,312			17
18	Directors Fees											18
19	Professional Services			30,640	30,640		30,640	2,294	32,934			19
20	Dues, Fees, Subscriptions & Promotions			17,562	17,562		17,562	2,100	19,662			20
21	Clerical & General Office Expenses	207,476	23,152	14,375	245,003		245,003	9,161	254,164			21
22	Employee Benefits & Payroll Taxes			286,559	286,559		286,559	28,316	314,875			22
23	Inservice Training & Education							137	137			23
24	Travel and Seminar			2,857	2,857		2,857	139	2,996			24
25	Other Admin. Staff Transportation							4,307	4,307			25
26	Insurance-Prop.Liab.Malpractice			28,483	28,483		28,483	879	29,362			26
27	Other (specify):*											27
28	**TOTAL General Administration**	310,788	23,152	596,045	929,985		929,985	(168,236)	761,749			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,423,412	340,187	962,978	3,726,577		3,726,577	(180,808)	3,545,769			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lexington of LaGrange #0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			26,218	26,218		26,218	103,359	129,577			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							189,004	189,004			32
33	Real Estate Taxes							200,362	200,362			33
34	Rent-Facility & Grounds			792,475	792,475		792,475	(792,475)				34
35	Rent-Equipment & Vehicles			1,504	1,504		1,504	188	1,692			35
36	Other (specify):*											36
37	**TOTAL Ownership**			820,197	820,197		820,197	(299,562)	520,635			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,439	979	53,418		53,418		53,418			39
40	Barber and Beauty Shops			17,081	17,081		17,081		17,081			40
41	Coffee and Gift Shops			3,560	3,560		3,560		3,560			41
42	Provider Participation Fee			59,842	59,842		59,842		59,842			42
43	Other (specify):* **Nonallowable costs**			39,649	39,649		39,649	(39,649)				43
44	**TOTAL Special Cost Centers**		52,439	121,111	173,550		173,550	(39,649)	133,901			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,423,412	392,626	1,904,286	4,720,324		4,720,324	(520,019)	4,200,305			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,329)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(6,212)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,267)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(838)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(550)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,751)	43		24
25	Fund Raising, Advertising and Promotional	(8,510)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,022)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(5,674)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (61,153)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(458,866)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (458,866)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (520,019)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lexington of LaGrange

ID# 0038083

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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78				78
79				79
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81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sambell of LaGrange		
James Samatas	22.33%			Limited Partnership	LaGrange	Real Estate ptsp.
John Samatas	22.33%	See attached Schedule B		Royal Mgmt. Corp.	Lombard	Mgmt. Co.
Cynthia Thiem	22.34%			Lexington Financial		
Jeffrey Bell, James Bell Declaration of Trust, Larry Bell				Services, L.L.C. II	Lombard	Finance Co.
and David Bell each owning 8.25%	33.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 792,475	Sambell of LaGrange Partnership	**	$	$ (792,475)	1
2	V	30	Depreciation		Sambell of LaGrange Partnership	**	97,251	97,251	2
3	V	32	Interest expense		Sambell of LaGrange Partnership	**	194,488	194,488	3
4	V	32	Amortization of mortgage costs		Sambell of LaGrange Partnership	**	1,777	1,777	4
5	V	33	Property taxes		Sambell of LaGrange Partnership	**	192,475	192,475	5
6	V	43	State replacement tax		Sambell of LaGrange Partnership	**	22	22	6
7	V	21	Bank charges		Sambell of LaGrange Partnership	**	225	225	7
8	V	21	Miscellaneous expense		Sambell of LaGrange Partnership	**	90	90	8
9	V	19	Professional fees		Sambell of LaGrange Partnership	**	10,977	10,977	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 792,475			$ 497,305	$ * (295,170)	14

** The owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Sambell of LaGrange Limited Partnership

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	FICA	$	Royal Management Corp.	**	$ 11,761	$ 11,761	15
16	V	22	FUTA		Royal Management Corp.	**	244	244	16
17	V	22	SUTA		Royal Management Corp.	**	656	656	17
18	V	22	Insurance - W/C		Royal Management Corp.	**	138	138	18
19	V	22	Insurance - Hospitalization		Royal Management Corp.	**	5,948	5,948	19
20	V	22	401 (k) and other emp. Benefits		Royal Management Corp.	**	3,111	3,111	20
21	V	30	Depreciation - vehicles		Royal Management Corp.	**	1,959	1,959	21
22	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	1,087	1,087	22
23	V	30	Depreciation - equipment		Royal Management Corp.	**	3,062	3,062	23
24	V	33	Property taxes		Royal Management Corp.	**	762	762	24
25	V	6	Repairs & maintenance		Royal Management Corp.	**	627	627	25
26	V	26	Insurance - general		Royal Management Corp.	**	879	879	26
27	V	6	Scavenger & exterminating		Royal Management Corp.	**	284	284	27
28	V	5	Utilities - gas & electric		Royal Management Corp.	**	927	927	28
29	V	5	Utilities - water & sewer		Royal Management Corp.	**	182	182	29
30	V	11	Activities Consultant		Royal Management Corp.	**	10	10	30
31	V	35	Equipment rental		Royal Management Corp.	**	188	188	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**	1,813	1,813	32
33	V	25	Auto expense		Royal Management Corp.	**	4,307	4,307	33
34	V	21	Bank charges		Royal Management Corp.	**	137	137	34
35	V	19	Computer consultant & supplies		Royal Management Corp.	**	2,666	2,666	35
36	V	20	Dues & subscriptions		Royal Management Corp.	**	287	287	36
37	V	21	Office supplies & printing		Royal Management Corp.	**	3,459	3,459	37
38	V	21	Postage		Royal Management Corp.	**	1,293	1,293	38
39	Total			$			$ 45,787	$ * 45,787	39

** Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Royal Management Corp.	**	$ 622	$ 622	15
16	V	6	Security service		Royal Management Corp.	**	6	6	16
17	V	21	Telephone		Royal Management Corp.	**	3,692	3,692	17
18	V	21	Communications		Royal Management Corp.	**	265	265	18
19	V	24	Travel & seminar		Royal Management Corp.	**	358	358	19
20	V	32	Interest		Royal Management Corp.	**	1,006	1,006	20
21	V	23	Training & education		Royal Management Corp.	**	137	137	21
22	V	17	Management fees	215,569	Royal Management Corp.	**		(215,569)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 215,569			$ 6,086	$ * (209,483)	39

** Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	2	4.00%	Salary	$ 13,653	L 17, C 1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	1	2.00%	Salary	6,068	L 17, C 1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	1	2.50%	Salary	7,585	L 17, C 1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	1	2.00%	Salary	2,427	L 17, C 1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	2	5.00%	Salary	4,035	L 17, C 1	5
6											6
7						All individuals work in excess of 40 hours per week.					7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 33,768		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	FICA	Bed Days	788,945	11	$ 232,594	$	39,894	$ 11,761	1
2	22	FUTA	Bed Days	788,945	11	4,830		39,894	244	2
3	22	SUTA	Bed Days	788,945	11	12,967		39,894	656	3
4	22	Insurance - W/C	Bed Days	788,945	11	2,735		39,894	138	4
5	22	Insurance - Hospitalization	Bed Days	788,945	11	117,633		39,894	5,948	5
6	22	401 (k) and other emp. Benefits	Bed Days	788,945	11	61,535		39,894	3,111	6
7	30	Depreciation - vehicles	Bed Days	788,945	11	38,735		39,894	1,959	7
8	30	Depreciation - leasehold improv.	Bed Days	788,945	11	21,505		39,894	1,087	8
9	30	Depreciation - equipment	Bed Days	788,945	11	60,561		39,894	3,062	9
10	33	Real estate taxes	Bed Days	788,945	11	15,061		39,894	762	10
11	6	Repairs & maintenance	Bed Days	788,945	11	12,408		39,894	627	11
12	26	Insurance - general	Bed Days	788,945	11	17,396		39,894	879	12
13	6	Scavenger & exterminating	Bed Days	788,945	11	5,608		39,894	284	13
14	5	Utilities - gas & electric	Bed Days	788,945	11	18,291		39,894	927	14
15	5	Utilities - water & sewer	Bed Days	788,945	11	3,608		39,894	182	15
16	11	Activity consultant	Bed Days	788,945	11	167		39,894	10	16
17	35	Equipment rental	Bed Days	788,945	11	3,709		39,894	188	17
18	20	Advertising - help wanted	Bed Days	788,945	11	35,848		39,894	1,813	18
19	25	Auto expense	Bed Days	788,945	11	85,184		39,894	4,307	19
20	21	Bank charges	Bed Days	788,945	11	2,695		39,894	137	20
21	19	Computer consultant & supplies	Bed Days	788,945	11	52,718		39,894	2,666	21
22	20	Dues & subscriptions	Bed Days	788,945	11	5,668		39,894	287	22
23	21	Office supplies & printing	Bed Days	788,945	11	68,404		39,894	3,459	23
24	21	Postage	Bed Days	788,945	11	25,535		39,894	1,293	24
25	TOTALS					$ 905,395	$		$ 45,787	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed Days	788,945	11	$ 12,334	$	39,894	$ 622	1
2	6	Security Service	Bed Days	788,945	11	127		39,894	6	2
3	21	Telephone	Bed Days	788,945	11	73,022		39,894	3,692	3
4	21	Communications	Bed Days	788,945	11	5,248		39,894	265	4
5	24	Travel & seminar	Bed Days	788,945	11	7,077		39,894	358	5
6	32	Interest	Bed Days	788,945	11	19,899		39,894	1,006	6
7	23	Training & Education	Bed Days	788,945	11	2,716		39,894	137	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 120,423	$		$ 6,086	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C. II	x		Mortgage	Varies	12/29/98	2,990,000	2,845,169	12/29/2008	0.0675	194,488	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,990,000	$ 2,845,169			$ 194,488	9
	B. Non-Facility Related*											
10								Amortization of loan costs			1,777	10
11								Interest income offset			(8,267)	11
12								Allocated from management company			1,006	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,484)	14
15	TOTALS (line 9+line14)						$ 2,990,000	$ 2,845,169			$ 189,004	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 208,000	1
	Allocated from Management Company	762	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 196,475	2
3. Under or (over) accrual (line 2 minus line 1).		$ (10,763)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 204,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 7,125	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 200,362	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	191,478	8
	1996	192,036	9
	1997	195,909	10
	1998	198,451	11
	1999	196,475	12

1999 taxes:	196,475
Estimated increase (4%):	1.04
Estimated 2000 taxes:	204,334
Use:	204,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,992 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	40,000	1991	$ 500,000	1
2					2
3	TOTALS	40,000		$ 500,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1992	1992	$ 2,661,448	$	35	$ 76,041	$ 76,041	$ 646,351	4
5	10		1995	1995	79,363	7,936	10	7,936		43,649	5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1992	1,152		20	58	58	491	9
10	Building Improvements			1992	2,714		31	271	271	2,306	10
11	Building Improvements			1993	2,901		35	83	83	621	11
12	Leasehold Improvements			1994	6,402	640	10	640		4,161	12
13	Leasehold Improvements - Corner Guards			1996	2,195	219	10	219		987	13
14	Wiring			1998	3,378	338	10	338		845	14
15	Resurface & Restripe Parking Lot			1998	3,753	375	10	375		938	15
16	Lobby Tile			1998	19,488	1,949	10	1,949		4,223	16
17	Resurface & Restripe Parking Lot			2000	1,997	100	10	100		100	17
18	Automatic Door			2000	1,300	65	10	65		65	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,786,091	$ 11,622		$ 88,075	$ 76,453	$ 704,737	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from management company			1995	5,145		35	159	159	810	9
10	Allocated from management company			1996	4,189		35	130	130	539	10
11	Allocated from management company			1989	144		31	4	4	59	11
12	Allocated from management company - HVAC			1998	108		35	3	3	9	12
13	Allocated from management company - Offices			1999	274		35	8	8	11	13
14	Allocated from management company - Offices			2000	129		35	4	4	3	14
15	Allocated from management company			1987	24,058		31	744	744	9,774	15
16	Allocated from management company			1993	12		39	1	1	2	16
17	Allocated from management company			1995	542		39	17	17	76	17
18	Allocated from management company			1996	109		39	3	3	11	18
19	Allocated from management company - Sidewalk			1998	224		39	7	7	14	19
20	Allocated from management company - Roof			1998	8		15	1	1	1	20
21	Allocated from management company - Awnings			1999	138		39	4	4	20	21
22	Allocated from management company - Parking lot			1999	65		15	2	2	4	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 35,145	$		$ 1,087	$ 1,087	$ 11,333	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 299,183	$ 13,770	$ 34,568	$ 20,798	5-10 years	$ 215,247	37
38	Current Year Purchases	8,258	826	826		5 years	826	38
39	Fully Depreciated Assets	11,727					11,727	39
40	Allocated from Management Company	30,171		3,062	3,062		21,353	40
41	TOTALS	$ 349,339	$ 14,596	$ 38,456	$ 23,860		$ 249,153	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45	Allocated from Management Company			13,072		1,959	1,959		8,033	45
46	TOTALS			$ 13,072	$	$ 1,959	$ 1,959		$ 8,033	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,683,647	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 26,218	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 129,577	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 103,359	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 973,256	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,692 Description: Copier - $1,504; Allocated from Management Company - $188
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [x] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10A, C 3	hrs	$	7,384	$ 67,309	$	7,384	$ 67,309	1
2	Licensed Speech and Language Development Therapist	L 10A, C 3	hrs		640	7,243		640	7,243	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10A, C 3	hrs		6,360	69,629		6,360	69,629	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C 2	# of prescrpts				47,362		47,362	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Oxygen Other (specify): Laboratory	L 39, C 2 L 39, C 3				979	5,077		5,077 979	13
14	TOTAL			$	14,384	$ 145,160	$ 52,439	14,384	$ 197,599	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 103,775	$ 120,260	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 221,426)	990,988	990,988	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,046	18,046	6
7	Other Prepaid Expenses	413	413	7
8	Accounts Receivable (owners or related parties)	18,454	18,454	8
9	Other(specify): See attached Schedule D		84,199	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,131,676	$ 1,232,360	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,426	2,426	12
13	Land		500,000	13
14	Buildings, at Historical Cost		2,664,349	14
15	Leasehold Improvements, at Historical Cost	117,876	156,887	15
16	Equipment, at Historical Cost	103,807	362,411	16
17	Accumulated Depreciation (book methods)	(99,290)	(973,256)	17
18	Deferred Charges		1,480	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized loan costs		31,979	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 124,819	$ 2,746,276	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,256,495	$ 3,978,636	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 118,855	$ 121,980	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,095	91,095	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,720	1,720	31
32	Accrued Real Estate Taxes(Sch.IX-B)		204,000	32
33	Accrued Interest Payable		16,004	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule D	135,672	52,910	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 347,342	$ 487,709	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,845,169	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,845,169	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 347,342	$ 3,332,878	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 909,153	$ 645,758	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,256,495	$ 3,978,636	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 965,580	1
2	Restatements (describe):		2
3	**Prior years post closing entries**	(71,473)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 894,107	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	879,046	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(864,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 15,046	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 909,153	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,312,135	1
2	Discounts and Allowances for all Levels	(202,023)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,110,112	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	264,067	6
7	Oxygen	4,004	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 268,071	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	5,010	12
13	Barber and Beauty Care	21,718	13
14	Non-Patient Meals	1,329	14
15	Telephone, Television and Radio	61	15
16	Rental of Facility Space		16
17	Sale of Drugs	52,929	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,286	19
20	Radiology and X-Ray		20
21	Other Medical Services	74,773	21
22	Laundry	6,212	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 166,318	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,267	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,267	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule D	46,602	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 46,602	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,599,370	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	856,011	31
32	Health Care	1,940,581	32
33	General Administration	929,985	33
	B. Capital Expense		
34	Ownership	820,197	34
	C. Ancillary Expense		
35	Special Cost Centers	113,708	35
36	Provider Participation Fee	59,842	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,720,324	40
41	**Income before Income Taxes (line 30 minus line 40)****	879,046	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 879,046	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity files a cash basis tax return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,511	2,622	$ 58,609	$ 22.35	1
2	Assistant Director of Nursing	1,981	2,102	48,328	22.99	2
3	Registered Nurses	24,942	26,747	585,083	21.87	3
4	Licensed Practical Nurses	11,032	11,988	210,474	17.56	4
5	Nurse Aides & Orderlies	50,291	53,078	540,818	10.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,039	5,412	60,491	11.18	8
9	Activity Director	1,989	2,221	27,844	12.54	9
10	Activity Assistants	9,115	9,288	72,677	7.82	10
11	Social Service Workers	3,633	3,979	48,127	12.10	11
12	Dietician	100	106	2,169	20.46	12
13	Food Service Supervisor	1,903	2,012	29,910	14.87	13
14	Head Cook	1,687	2,012	25,304	12.58	14
15	Cook Helpers/Assistants	12,232	12,913	98,543	7.63	15
16	Dishwashers	8,553	8,818	54,588	6.19	16
17	Maintenance Workers	2,851	3,002	37,085	12.35	17
18	Housekeepers	22,615	24,242	169,470	6.99	18
19	Laundry	6,520	6,881	43,104	6.26	19
20	Administrator	2,001	2,108	69,544	32.99	20
21	Assistant Administrator					21
22	Other Administrative	328	335	33,768	100.80	22
23	Office Manager					23
24	Clerical	13,382	14,501	207,476	14.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,705	194,367	$ 2,423,412 *	$ 12.47	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 7,881	L 1, C 3	35
36	Medical Director	Monthly	7,200	L 9, C 3	36
37	Medical Records Consultant	17	850	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,266	L 11, C 3	44
45	Social Service Consultant	Monthly	2,258	L 12, C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	17	$ 22,655		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Deborah Morris	Administrator	0.00%	$ 27,402
Chris Andersen	Administrator	0.00%	42,142
John Samatas	Admin/Plant Ops	22.33%	6,068
James Samatas	Administrative	22.33%	13,653
Cynthia Thiem	Administrative	22.34%	7,585
George Samatas	Administrative	0.00%	2,427
Jason Samatas	Administrative	0.00%	4,035
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 103,312

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 215,569
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 215,569

C. Professional Services

Vendor/Payee	Type	Amount
American Express Tax & Bus. Svs.	Accounting	$ 5,926
Altschuler, Melvoin & Glasser LLP	Accounting	13,486
Aetna Life Insurance & Annuity	401(k) administration	630
Commitment Consulting	Collections	1,525
Freedman, Anselmo & Lindberg	Collections	197
Holleb & Coff	Legal	584
Personnel Planners	U/C Consulting	806
James Samatas	Legal	50
Royal Management Corp.	Web site development	338
Christine Toolan	Management Consulting	60
Systematic Management	Billing Consultant	4,122
See attached Schedule E		2,916
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 30,640

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,620
Unemployment Compensation Insurance	18,180
FICA Taxes	179,768
Employee Health Insurance	62,541
Employee Meals	6,458
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contributions	13,993
Other Employee Benefits	9,315
TOTAL (agree to Schedule V, line 22, col.8)	$ 314,875

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	16,430
Health Care Worker Background Check	
(Indicate # of checks performed 25)	300
Miscellaneous Licenses & Permits	405
Miscellaneous Dues & Subscriptions	427
Allocated from Management Company	2,100
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,662

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,638
Allocated from Management Company	358
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,996

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Deferred Maintenance	Sept., 1998	$ 1,742	3 years	$	$ 290	$ 581	$ 581	$ 290	$	$	$	$
2	Painting & Decorating	Various 2000	1,428	3 years				238	476	476	238		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,170		$	$ 290	$ 581	$ 819	$ 766	$ 476	$ 238	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **35,943** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,842**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **6,458** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,329**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.